

INSTRUCTIONS FOR COMPLETION OF THE
“NOTIFICATION FROM LONG-TERM CARE FACILITY OF
ADMISSION OR TERMINATION OF A MEDICAID PATIENT” (LTC-2)
FOR ADMISSIONS AND TERMINATIONS

SECTION I - PATIENT INFORMATION

1. Name - self explanatory
2. Social Security Number - patient's number
(Note: the Medicare number is NOT ALWAYS the patient's SSN)
3. HSP#-12digit Medicaid Number, if available
 - (Confirmed By: Give name of CWA approving financial eligibility)
4. Authorized by _____ Long Term Care Field Office (LTCFO)
(LEAVE #4 BLANK IF THIS IS A TERMINATION)
 - Indicate the **field office** that approved the case
(Note: Refer to Approval Letter (LTC-13B) or the Transfer Approval Letter)
 - A. If **another** field office approved the case, send the LTC-2 to the LTC Field Office that serves the facility - **DO NOT** send the LTC-2 to the authorizing field office.
 - B. This will remain blank for Private to Medicaid and PAS Exempt (20 Day Medicare subacute cases.)
 - Date of Birth-self explanatory
5. Sex - self explanatory

SECTION II - PROVIDER INFORMATION

1. Provider Number-7 digit UNISYS provider number
- 2.-4. Facility name and address
5. Long Term Care Field Office: _____ LTC Field Office
Address

SECTION III - ADMISSION INFORMATION
(IF THIS IS A TERMINATION, SKIP TO SECTION IV)

1. Admission Date-date patient was admitted to the facility
 - For Private to Medicaid cases this date should reflect the date the patient was originally admitted to the facility. This type of case should be sent to the field office **6 months prior** to the anticipated date of conversion to Medicaid.
2. Admitted to Room Number and Bed Number-self explanatory
3. Admitted from-check appropriate location:
 - Community/Boarding Home
 - Medicare to Medicaid
 - Psychiatric Hospital
 - Private to Medicaid-complete “anticipated Medicaid Effective Date”
(Note: It is no longer necessary to attach PA-4)
 - Hospital - Acute Care Hospital or Rehab Hospital-**also** complete #5
 - A. Check this category for “PAS Exempt” cases that require more than 20 days Medicare subacute. Also type **“PAS EXEMPT”** in the **“Other”** category below.
 - Other Long Term Care Facility (LTCF)-**also** complete #5
 - Other (specify)-use this category if above categories do not apply or to identify **“PAS EXEMPT”** cases

4. Name and Address of Hospital/LTCF
 - Admission Date-self explanatory
5. If admitted from Hosp/LTCF, give the name/address of previous residence-self explanatory

**SECTION IV. TERMINATION INFORMATION
(IF THIS IS AN ADMISSION, SKIP TO SECTION V)**

1. Discharge Date-date patient was permanently discharged from the facility
2. Discharged to: (check one)
 - Own Home - (check either) With Medicaid Services or Without Medicaid Services
 - Relative's Home - (check either) With Medicaid Services or Without Medicaid Services
 - Assisted Living (Name and County)
 - Other LTCF (Name and County)
 - Other (specify) - use this category if above categories do not apply. Include name and address of "Other"
 - Telephone Number of Discharge Site - self explanatory
3. Death (Date)-self explanatory
 - Check "In LTCF" **or** "In Hospital"

SECTION V. CERTIFICATION

1. Complete Name, Title and Date

SECTION VI. CWA USE ONLY (TO BE COMPLETED BY CWA ONLY)

GENERAL INFORMATION FOR NURSING FACILITIES:

Send an LTC-2 for all new admissions that have been prescreened and Private to Medicaid and PAS Exempt cases.

N.J.A.C. 10:63-1.8 (k) mandates the nursing facility (NF) to submit the LTC-2 (formerly MCNH-33) form to the Field Office serving the county where the NF is located within two working days.